Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS667HOS	A. BUILDING _____ B. WING _____	C 10/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HOSPITAL MEDICAL CENTER	620 SHADOW LANE LAS VEGAS, NV 89106

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S 000	Initial Comments This Statement of Deficiencies was generated as the result of a State Licensure complaint investigation survey conducted at your facility on 10/14/08 through 10/17/08. A total of 21 complaints were investigated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00019052 was unsubstantiated. Complaint #NV00019363 was unsubstantiated. Complaint #NV00018956 was unsubstantiated. Complaint #NV00017754 was substantiated. (See Tag 0300). Complaint #NV00018267 was unsubstantiated. Complaint #NV00016693 was unsubstantiated. Complaint #NV00018962 was unsubstantiated. Complaint #NV00015961 was substantiated with no deficiencies. Complaint #NV00017372 was unsubstantiated. Complaint #NV00017373 was unsubstantiated. Complaint #NV00017554 was unsubstantiated. (unable to identify patient) Complaint #NV00016811 was unsubstantiated.	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 000	Continued From page 1 Complaint #NV00016850 was substantiated with no deficiencies. Complaint #NV00018735 has not been finalized. Complaint #NV00017830 was unsubstantiated. Complaint #NV00018746 was unsubstantiated. Complaint #NV00017607 was unsubstantiated. Complaint #NV00018470 was unsubstantiated. Complaint #NV00018603 was unsubstantiated. Complaint #NV00020235 was substantiated. (See Tag 0293) Complaint #NV00018214 was unsubstantiated.	S 000		
S 293	NAC 449.361 Nursing Services 4. A hospital shall have a system for determining the nursing needs of each patient. The system must include assessments made by a registered nurse of the needs of each patient and the provision of staffing based on those assessments. This Regulation is not met as evidenced by: Based on interviews and policy review, it was determined the facility failed to provide evidence of a system for assessing the individual needs of each patient and providing staffing based on those assessments. Findings include: An interview with the chief nursing officer (CNO)	S 293		

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S 293	Continued From page 2 on 10/14/08 revealed the facility no longer used individual nursing assessments to determine staffing levels. The CNO indicated there was a criteria for determining acuity levels used in the past, but was no longer in effect. On 10/17/08 a review of the staffing policy of the facility's sister hospital revealed a criteria for determining acuity levels of individual patients. The CNO of Valley Hospital indicated their facility did not share departmental policies between sister facilities and Valley Hospital did not have an acuity criteria procedure such as the facility's sister hospital. On 10/14/08 at approximately 2:00 PM, Manager #1 was interviewed. She was responsible for the Three Tower Unit. She reported that staffing levels are determined by using a staffing grid. She stated that the grid was unique to the Three Tower Unit. She stated that an individual patient's care needs were not considered when making the grid. She stated that the unit charge nurse takes individual patient acuity into consideration when making nursing shift assignments. Review of staffing records revealed a form entitled "Daily Productivity Record". The form indicated that on 10/13/08 there were no level one patients, 10 level two patients, 14 level three patients, 14 level four patients and no level five patients. The unit manager reported that the levels were acuity levels but that they were not used to determine daily staffing of the two shifts. She was able to give general examples of what each acuity level might be but stated the levels were a night shift duty and the night nurse would know how each level was determined. She could not find a policy and procedure that would define	S 293		

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S 293	Continued From page 3 each acuity level. She could not identify the names of the patients assigned to each level. The Manager reported that she was covering the Four Tower unit today. She presented a staffing grid for the Four Tower Unit. She described the grids use as the same on the Three Tower Unit. She stated that individual patient acuity level was considered by the charge nurse when making shift assignments but could not identify the acuity levels of individual patients currently on the Four Tower Unit. Review of the staffing records again revealed the Daily Productivity Form. The Manager reported that the night nurse completed the form and that there was no policy and procedure for filling out the form. The Charge Nurse stated there used to be a procedure for determining patient acuity but it was an old procedure. She stated that the night nurses knew how to determine the different acuity levels but that those levels did not have an effect on staffing of the next shift. On 10/15/08, the Charge Nurse of Two North was interviewed. She also had a staffing grid. She stated that staffing assignments were determined by the grid. She stated that a charge nurse may also consider the acuity level of a patient in determining staffing assignments. The Daily Productivity Form revealed that the night nurse had identified the numbers of patients currently on the floor according to their acuity level. The charge nurse did not know the acuity levels of individual patients currently on her unit. She reported that the night shift nurse knew how to make acuity level determinations. She was unable to find a policy that defined each acuity level. She gave a general description of what she thought might be appropriate for each level but	S 293		

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S 293	Continued From page 4 was not sure if her description was accurate. She stated that an acuity level five patient on her unit would require total care. On 10/16/08 at approximately 2:10 PM, Manager #4 was interviewed. She was the manager of Two North. She confirmed that the night shift determined acuity levels and those levels were not used to determine immediate staffing needs and assignments. She was unable to find a policy and procedure addressing how the acuity levels were used and how levels were determined. She stated the the night shift staff had worked at the facility for several years and knew how to determine acuity. She reported that a level five acuity patient was in need of intensive care and would not be a patient on her unit. She could not identify the acuity level of each patient currently on the unit. On 10/16/08, Manager #6 was interviewed. She was the manager for Four Pavilion Unit. She also used a staffing grid to determine staffing levels. She stated that the acuity levels identified on the Daily Productivity Form did not determine staffing assignments for the shift. She could not identify the acuity levels of individuals of each patient on her unit. An interview was conducted on 10/15/08 with the Two North relief charge nurse. She stated that staffing was done by acuity but could not provide any documentation that could support that. She did provide a Staffing Grid Guideline that was based on census and nursing hours. An interview was conducted on 10/16/08 at 4:35 PM, with the Two North night charge nurse via telephone. She stated she was responsible for determining the staffing needs for the following	S 293		

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S 293	Continued From page 5 shift. She stated she looked at the number of patients and their acuities and determined the number of licensed staff needed. This surveyor asked her how she determined acuity levels and she replied, "I have been working here so long I just know." Upon further questioning she said there was a book or chart somewhere with acuities written out but she was unable to say where. Severity: 2 Scope: 3	S 293		
S 300	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to prevent an Alzheimer's patient from eloping. (Patient #1). Findings include: Patient #1 was admitted to the facility on 3/24/08 with the diagnosis of Alzheimer's disease following three days of increasing confusion and possibly ingesting dishwashing detergent. She was admitted to a room on 4 Tower. Patient #1's son was interviewed per telephone on 1/2/09. The interview revealed he was the Power of Attorney for Health Care for his mother,	S 300		

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S 300	Continued From page 6 and that he received a call on 3/25/08 that his mother had been discharged and needed to be picked up. He stated that he and his son were walking from the parking lot to the hospital's main entrance when they were about to enter the hospital he saw his mother standing behind a light pole, as if she were going to cross the street. The street was observed to be a four lane city street. Patient #1's son stated that he brought his mother back to her room on 4 Tower. He stated that he discussed his mother's elopement with the nurses and one of the nurses stated, "Not again?". He asked the nurse, "You mean this is not the first time she left the floor?" He stated that the nurse told him that his mother had left the floor previously. He was not informed of that incident. He then asked them if they had a policy for Alzheimer's patients. He stated he then signed her discharge paper work and left the facility with his mother. Patient #1's medical record was reviewed. The discharge summary listed her admission diagnoses as altered mental status, hypertensive urgency, and dementia. Review of the nurse's notes revealed the following entry on 3/25/08, at 6:15 PM: "Son came to pick up pt, per son pt was downstairs, pt was in her room at 1805 (6:05 PM) reading the newspaper." On 10/16/08, the charge nurse, Employee #5, was interviewed. She stated she was on maternity leave during the time of Patient #1's admission to the facility. She stated that the nursing unit had eight camera rooms. The room Patient #1 was admitted to was not a camera room. Patient #1's room was observed to be two rooms from the nursing station and was not visible from the nursing station. The exit door closest to Patient #1's room was alarmed.	S 300		

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S 300	Continued From page 7 Patient #1 had to walk down two halls to access the elevator in order to leave the floor. On 10/16/08, the former Unit Manager, Employee #12, was interviewed. The interview revealed that she recalled that the nurse who was taking care of Patient #1 stated that the patient had been in and out of the room all day. The patient would sit in a chair outside of the room and read the newspaper. Employee #12 stated that the nurse had noted Patient #1's presence outside of the room about every 15 minutes. She stated that the nurse told Patient #1 that she had been discharged and to wait for her son so she could go home. Per Employee #12, Patient #1 apparently went downstairs to the lobby to wait for her son. Employee #12 stated that she had been told that Patient #1's son brought her back to the floor for discharge. On 10/16/08, the patient advocate, Employee #13, was interviewed. He recalled talking with Patient #1's son regarding the elopement. He stated that his interview with Patient #1's son revealed that he and his son were walking from the parking lot when they saw Patient #1 outside of the facility and ready to cross the street. The patient advocate did not know about any previous elopement attempts by Patient #1. Review of the facility's risk management inquiry revealed an entry regarding the lost dentures and the following entry, "pt (patient) was also d/c (discharged) home son came up and said he found his mother down stairs. Nurse stated she saw pt at 1805 (6:05 PM) sitting in bed reading paper and wasn't aware she walked off." A second entry revealed an entry by Employee #12, "The pt had been sitting in the hall and would go	S 300		

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S 300	Continued From page 8 back and forth to her room and to the nurses station. The nurse had stepped into another room and said she saw her at 6:05 PM. The son saw the pt downstairs approximately 6:10 PM. Pt was okay and waiting for him." Review of Patient #1's medical record failed to reveal any notation of a previous elopement. Further review of the medical record failed to reveal a care plan for the risk of elopement. Severity: 3 Scope: 1	S 300		